Aetna

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Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Docket No. HHS-OS-2010-0029
Attention: OCIIO-9999-P
Room 455-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Rate Increase Disclosure and Review—Response to Proposed Rule of Proposed Rulemaking Regarding Section 2794 of the Public Health Services Act

Dear Secretary Sebelius:

Aetna welcomes the opportunity to respond to the Department of Health and Human Services' (the "Department's") Notice of Proposed Rulemaking Regarding Section 2794 of the Public Health Services Act ("PHSA"), concerning the rate review process established by the Patient Protection and Affordable Care Act ("ACA"), as published in the December 23, 2010 Federal Register (75 Fed. Reg. 81004) (the "Proposed Rule").

Aetna is one of the nation's leading diversified health care benefits companies, providing members with information and resources to help them make better informed decisions about their health care. Our programs and services strive to improve the quality of health care while controlling rising employee benefits costs. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services, including medical, pharmacy, dental, behavioral health, group life, and disability plans and medical management capabilities.

An appropriate rate review process is critical to the well-being of consumers. Today, Aetna submits rate requests that incorporate the impact of differences in cost of care for various geographies within a state, changes in enrollee risk profile, and the impact of increases in provider charges as well as increasing utilization. These factors determine the overall cost of coverage and therefore the rate level requested. Actual rates applicable to a specific Small Group or Individual customer vary based on location, risk profile (including drivers such as age or medical conditions where permissible) and the benefit plan selected.

Politicized rate review leads to problematic consequences. This was historically a problem in New York in the late 80's and 90's. According to the New York Health Plan Association, "For many years, the State suppressed Empire's rates, especially in the individual market. Eventually this politically-motivated rate suppression contributed to the Empire's financial weakness and for a time

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endangered Empire's ability to continue providing coverage. There is no serious dispute that the Department's politically-motivated rate suppression ultimately put consumers at risk of losing their Empire coverage."[1]

The President of the Amherst Chamber of Commerce concurs saying, "Prior approval hearings were always political. In election years, the department would keep premium increases minimal despite being presented data on the rising cost and increased usage of health care goods and services."[2]

Maine is a more recent example. A rate review process that denies actuarially developed rates and other regulatory issues has resulted in only two insurers remaining in the Maine individual market – with one insurer having two thirds of the market. This aggressive regulatory position has not resulted in affordable premiums – in fact just the opposite. A 35 year old pays as much as $509 per month for a basic policy that has a $2250 deductible.[3]

This is because the real drivers of premiums are provider costs. Kansas Insurance Commissioner Sandy Praegar summed up the situation by saying, "If you want to keep costs under control, it's not about managing health care premiums…it's about managing the underlying health care costs."[4]

An investigation by the Massachusetts Attorney General found that medical price increases accounted for 80% of total medical expenses for one major payer.[5] In the span of one year, over 50 hospitals nationwide requested increases exceeding 20% from Aetna. One California community faced a medical trend increase of almost 39% for the first three quarters of 2009.[6]

The insurance industry will continue to justify its rates through proper actuarial measurement but if we are the only ones doing so in the health sector, and if our rates are held hostage to the political environment, this regulation will harm not only consumers but providers as well.

The potential negative impacts of a highly politicized rate review environment include:

- *Health plan insolvencies:* While the federal regulation ostensibly leaves rate approval authority to the states, if it creates unworkable expectations it could create undue pressure on states to delay or deny necessary premium increases. This path could be politically popular in the short term, but would leave successor commissioners with financially weak and potentially insolvent insurers. Both providers and consumers would be at risk of widespread unpaid claims.

- *Reduced competition*: A federal regulation that creates unreasonable expectations about the role of state insurance commissioners and the level of suspicious premium increases also could drive insurers out of some state individual and small group markets. Cumbersome rate processes could increase the administrative costs of operating in a state beyond acceptable levels. States with smaller populations or where an insurer has a smaller footprint would be particularly vulnerable to insurer exits.

  These insurer exits would leave consumers with less choice – just as exchanges are being proposed as a facilitator of choice. This will leave consumers unhappy and

disappointed with the performance of exchanges – even though rate review is largely outside the control of exchanges. In addition, reduced competition could result in higher premiums over time as larger insurers dominate a state.

- *More limited provider choice:* Regulatory environments that delay or deny necessary premium increases also will lead to reductions in provider choice. While the marketplace has clearly chosen preferred provider organizations (PPOs) as a top choice for consumers, PPO premiums are more variable than tightly-controlled, narrow provider networks. Therefore, insurers that choose to stay in highly regulatory environments could migrate all of their products to closed provider networks that severely limit provider choice. Most consumers are likely to be unhappy if their only choice in a marketplace – or an exchange – is a closed network with limited provider choice.

- *Higher administrative costs and less innovation:* It is important to recognize that the extensive rate filings required today already impose considerable cost – about one million dollars per year. If the federal regulation drives states to significantly expand the administrative costs associated with rate review, this will lead to higher premiums for consumers – as they ultimately pay for state insurance personnel – and squeeze out the ability of insurers to innovate for the benefit of consumers. We estimate that the current proposed regulation could increase our filing costs by nearly 80%. This would challenge the ability of insurers to pursue projects desired by our customers and provider partners. For instance, we are currently participating in pilot projects in Ohio and New Jersey to simplify administrative costs for providers. However, the extension of worthy projects such as these will be threatened by additional bureaucratic filing costs.

We are encouraged that the proposed regulation expresses the intent of the federal government to defer to state decisions on rate review. However, we are concerned that the current proposed regulation may artificially box states into a "no win" situation. The proposed regulation fosters the false impression that any premium increase exceeding ten percent (10%) is suspiciously high and warrants extensive additional review. If states modify their practices in response to the Proposed Rule, they will create an unviable business environment for insurers and will dramatically increase their state budgets as well as administrative costs in the health care system. However, states that resist this will be labeled as "soft on insurers" and potentially vulnerable to criticism. We encourage the Department to rework the Proposed Rule to set reasonable expectations among consumers and allow states to exercise their expertise at efficiently and effectively targeting their resources to scrutinize real outlier premium increases without unnecessarily increasing administrative costs.

We also urge the Department to revise the Proposed Rule to ensure that it provides useful information to consumers. As currently drafted, we think the rule could lead to significant confusion among consumers because rate reviews may be untimely and after-the-fact and consumers will be deluged with complex and misleading information.

Below, we provide our recommendations to ensure that the rate review rule functions to protect and inform consumers, appropriately defer to state regulatory expertise, while not undermining the health of the insurance markets.

1. The Large Group Market Should Not Be Reviewed

The Proposed Rule adopts state definitions of the individual and small group markets and excludes large groups from the proposed regulation. Unlike individual consumers or small employers, large groups are sophisticated purchasers with a well-established infrastructure available to assist them in their negotiations with carriers. We appreciate the fact that the Proposed Rule recognizes that the large group market is functioning well and providing extensive coverage and good value to consumers. Approximately 99% of employers over size 200 provide coverage to their employees and 95% of employers size 50 to 199 provide coverage. On average, employees of large employers pay only 19% of the individual premium and 27% of the family premium.

Large employer premiums are highly customized. They are dependent on the benefit package – which varies significantly across large employers – as well as the actual claims experience of the workforce. Application of this regulation to the large group market would be unnecessary and unworkable. It could only hurt the success of today's large group market. The National Association of Insurance Commissioners ("NAIC") concurs as well, saying: "Some large employers and associations are exempted by many states from rate review, because they negotiate the rates with the insurer based on their own experience, and have the ability to change insurers if they are dissatisfied." NAIC Response to Request for Information Regarding Section 2794 of the Public Health Service Act, Adopted by the Executive Committee/Plenary May 12, 2010.

Recommendation: Given the critical distinctions between large groups and small groups/individual consumers, we recommend that the Department's final rule continue to exclude large groups from the scope of the regulation and continue to defer to state definitions of individual and small group markets.

2. The Ten Percent (10%)Threshold to Trigger a Rate Review Is Unsupported and Unwise

The Proposed Rule imposes a ten percent (10%) "trigger" on premium increases in the individual and small group markets. Insurers that file rates in excess of this will face additional reporting requirements and scrutiny. We believe the ten percent (10%) threshold is problematic. Specifically, this trigger level will:

- *Always be unreasonably low:* The 2011 Segal Health Plan Cost Trend Survey expects trend to exceed 10% across the board in 2011. Expected trends (without prescription coverage) will be 12.7% for Fee-for-Service plans, 11.7 percent for high deductible health plans, 11% for PPO/POS plans and 10.2 percent for HMOs. Trend expectations for coverage with prescription coverage is slightly lower but still exceeds ten percent in all categories except HMOs which is expected to be ten percent even. In addition, it is important to recognize that most individual market coverage does not include prescription coverage at this time.

- *Unnecessarily increase administrative costs*: The Department's own research found that "the majority of increases in the individual market exceeded 10 percent each year for the past 3 years" and that while slightly lower, "over 40 percent of increases" in the small group market exceeded ten percent. For instance, for Aetna, this would have triggered about 75% of our filings last year. For each of these filings, we estimate that it would require extensive work for highly-skilled employees. We

In addition, we anticipate that the additional data that we submit would require the insurance department to have additional actuarial FTEs to review the data. We estimate that states would need to increase existing actuarial staff by approximately 400% across the country to review this data. As actuaries are highly-skilled individuals, we believe this cost alone would average between ½ and ¾ million dollars per year per state. All of this would need to occur at a time when state budgets are already stretched thin. Insurance departments typically fund additional staff through premium taxes – which just increase premiums further.

- *Mislead consumers about premium increases:* The ten percent (10%) threshold also implies to consumers that any premium increase that exceeds ten percent is unreasonable. As mentioned above, this ignores the reality of trend expectations. In addition, it furthers misunderstanding about the components of premium increases. Premiums are mostly comprised of:

  - Provider charge increases: While this varies across the country, it is quite substantial everywhere. Increases in provider charges is the most significant component of medical cost trend and, therefore, to premiums, accounting for approximately 50 - 60% of underlying medical cost trend. Provider charges to private payors are particularly high due to the cost shifting impacts from public programs such as Medicare and Medicaid.

  - Utilization changes: Utilization increases account for an additional 20 – 30% of underlying medical cost trend and premium increases. Utilization increases occur due to providers ordering more testing (such as EKGs, lab tests, MRIs, etc) as well as individuals visiting physicians on a more frequent basis.

  - New Technologies: As new technologies emerge, they may be done in addition to current procedures or tests and/or are at a higher cost than for the technology they replace. This accounts for 10 – 15% of medical cost trend.

  - Leveraging: As discussed below, products with higher deductibles will experience higher premium trends due to the leveraging impact of the deductible. This may account for 5 – 20% of premium increase depending on the level of the deductible, out of pocket limits and other cost sharing mechanisms.

  - Adverse Selection: This is highly dependent on an insurer's actual covered population and can significantly impact a premium change.

  - Taxes: Taxes are often set as a percentage of a premium. Therefore, the fact that premiums increase every year results in a higher dollar amount in taxes paid every year. This magnifies the dollars of premium increase. In addition, new taxes or assessments may be added that also increase the cost of insurance.

- Other government requirements: Every year states – and often the federal government – require changes to health policies. These changes sometimes take the form of mandated benefits (e.g., infertility) but sometimes take the form of other costs such as enhanced appeal processes.

A review of insurance company profits in recent years demonstrates that insurance profit is NOT a key driver of premiums. In 2009, the insurance and managed care industry's profit margin was 2.2%, while the pharmaceutical industry's margin was 19.3% and the medical products and equipment industries' margin was 16.3%. *See* Fortune 500 Top industries: Most profitable for 2009.[7] It seems clear rate increases have been and will continue to be driven by the underlying medical cost trends, not insurer margins. *See, e.g.*, PriceWaterhouseCoopers Health Research Institute, Behind the Numbers, Medical Cost Trends for 2010 (noting that while prices of finished goods and services generally have fallen during the recession, producer prices within the healthcare sector have risen or remained steady during the period).

According to the Centers for Medicare and Medicaid Services, the most significant components of health care costs in 2008-2009 were hospital care (32%), physician and clinical services (24%) and other professional services (11%). Program administration and the net cost of insurance were only 2%. It is also important to recognize that existing government programs drive higher premium in the private sector. This is known as "cost shifting" and it occurs because the government underpays doctors and hospitals for Medicare and Medicaid services. Therefore, the providers charge higher prices to privately paid patients – or "cost shift" to the private sector. Milliman estimates that cost shifting resulted in a typical insured family paying 11% more in premiums than they would have if the government paid appropriate prices.

In addition, consumers and small employers are unlikely to understand the difference between structural rate increases and the actual premium increases they face themselves. For instance, individuals and small employers are likely to see premium changes that reflect changes in age, geography and for employers, changes in claims and workforce composition. When added to underlying trend, changes in any of these categories could result in an individual or small employer facing a premium increase of fifteen or twenty percent even if the underlying rate change was only ten percent.

- *Hurt high deductible health plans:* In addition, products offered in the consumer-directed and high-deductible health plans arena are unfairly targeted by a 10 percent threshold. Premiums for plans with a higher deductible will go up faster than other plans due to the higher increases they will experience in covered medical costs. For example, a member with $4,000 in annual costs this year may be expected to have $4,400 for next year. If the benefit plan is a $100 deductible, then the covered medical costs would increase from $3,900 to $4,300, or a 10.3% increase. If the same member has a $1,000 deductible, the covered medical costs would increase from $3,000 to $3,400, or a 13.3% increase. This increase in medical costs translates into a similar increase in premium.

Recommendation: In states with effective review processes, the Department should defer to the state's determination of which rates should be reviewed as well as what rate

increases are considered unreasonable. The Department should not attempt to dictate to effective states which rates they must review, using a fixed percent or otherwise.

In any states lacking an effective review process, the Department should use the average rate increase of all carriers in the market in that state, as reported on the NAIC form, plus 3 percent. The average should not be weighted – otherwise it will be completely driven by the largest insurer and not reflect a real outlier test. Any rate over the average +3% would be subject to Departmental review. In addition, the percentage should vary by state and by market (*i.e.*, individual versus small group) to account for differences in markets and products.

3. If Retained, the Federal Trigger for Rate Review Requires Clarification

As described above, we believe the ten percent (10%) trigger threshold is problematic. However, if the Department continues to use either ten percent -- or any other federal trigger for rate reviews -- we recommend that the Department clarify the factors that should be considered in determining whether or not a rate increase is in excess of the federal trigger (*e.g.*, 10%). The goal should be to measure old and new rates on an "apples-to-apples" comparison, measuring the amount of increase for the same amount of risk covered. Because both products and populations change, simply comparing the "old" and "new" rate would not show a true percentage change for the value of what the consumer is buying. Many factors may change the actual risk and value of the policy – *e.g.*, the age and gender of those insured (who is covered). A percentage calculation must be adjusted for those and other actuarial differences to provide useful and meaningful information to consumers. Accordingly, regardless of what process the Department decides to use as a trigger for rate reviews, we recommend that the Department clarify the factors that should be considered in calculating the average rate increase.

The preamble to the Proposed Rule clearly distinguishes between "premium increases" and "rate increases" –

> "[A] 'rate increase' alters the underlying rate structure of a policy form, while a 'premium increase' can occur even without any increase (or change) to the underlying rate structure. For example, for policies that are age-rated, as the duration of the policy advances, premium changes that correlate with age bands are not 'rate increases' since they do not change the underlying rate structure."

75 Fed. Reg. at 81009. While this statement is helpful, it should be expanded to include other changes that can cause individual premium changes, but should not be considered in calculating a rate increase. Also this statement is not incorporated into the text of the regulation.

Recommendation: To support a properly functioning insurance market, and to allow the rate review process to separate truly unreasonable increases from increases that are not part of the underlying rate structure, the calculation of the rate increase should include the following:

- Changes in underlying rating factors relating to *the underlying* rate structure such as changes in age/gender *factor tables*, changes in area *factor tables*, changes in industry factor tables, and changes in case size factors, but not including changes reflecting changes in the covered population (see below).

- Changes in rate level due to trend factors or changes in effective date factors.

- Changes in plan pricing factors, exclusive of any premium changes due to benefit changes.

- Uniform benefit modifications initiated by the insurer.

The rate increase calculation should exclude the following factors:

- Changes that are specific to a policyholder, including changes in demographics (age/gender/tier composition of an individual or group), changes in the size of a group, changes in the location of a group, changes in the industry of a group.

- Changes in a product's medical underwriting factor due to either an improvement or a deterioration of a product's relative morbidity.

4. Revise the Criteria By Which States Are Considered "Effective"

Aetna strongly supports the Department's decision to defer to state review processes. States are in the best position to most efficiently and effectively prioritize and utilize their resources to protect their consumers and ensure the competitiveness and stability of their own health insurance market. State regulators are familiar with their unique market and have various ways, both formal and informal, of monitoring products and carriers in their states; they are able to focus on critical products or market segments and consider the impact of any particular rate on the entire market. State regulators also have deep expertise not only with the needs of their consumers, but with the experience and histories of various carriers and products. Finally, state regulators are best able to judge what rate increases are necessary for a robust, competitive and flourishing market in their state and which increases are excessive, discriminatory or unjustified.

Given that the large majority of states already require extensive filings from insurers with respect to premium rates, a separate federal process adds unnecessary administrative costs and overall burden to the system. Such additional costs and burdens would deluge the Department with thousands of rate filings each year, most of which already were part of a state filing process. As a result, we believe that the rate review regulation should focus more on leveraging a state's current processes to minimize administrative burdens and unnecessary costs on the health care system and state budgets. However, the regulation's detailed criteria for a state to be considered "effective" are unnecessarily prescriptive, mandating not simply that a state have an effective rate filing process, but detailing precisely how that process must be done.

For example, the list of items is section 154.301(a)(4) is excessive. It is not necessary to review data at the level prescribed in the Proposed Rules in every case, and the list of data elements which *must* be reviewed is so exhaustive as to impose a significant burden on the state. If the proposed requirements are implemented, very few if any

states would be found to have an effective rate review process. This would in effect negate the efforts of the Department to work within the existing process and allow the states to continue to manage their markets.

The threshold for an effective rate review process should be based on a general description of the types of review that ought to be done, rather than an exhaustive list that must be done. Some of the data and the detail requested are not necessary in order to review a rate request for reasonability, such as medical cost trend and utilization trend by major service categories. Some of it is not even readily available in many cases, such as cost-sharing changes by major service categories. Whether the state reviews historical medical trends by major service category or by plan type or by rating area should not affect the determination of the effectiveness of its rate review process. If the state's process, when viewed in the aggregate, affords the state the opportunity to obtain and understand the data necessary to review the reasonableness of the assumptions and the validity of the data, then the process should be deemed to be effective.

The Department should carefully consider the adverse impact of these onerous requirements. The additional administrative burdens coupled with the market pressure that will result from actuarially sound rates being labeled as "unreasonable" may cause insurers to pull out of certain markets, destabilizing those markets and reducing consumer access and choice. Duplicative or unnecessary review processes will hurt consumers, as the costs of review will inevitably be borne by consumers through increased taxes or increased premiums. Rather than micromanaging how states review rates and increasing the cost of coverage for consumers, we believe that the Department's resources are better spent leveraging state expertise.

We are concerned that the Department's detailed requirements for states to meet in order to be considered "effective" will, as a practical matter, ensure that the Department will shoulder the vast majority of rate review. States best understand their markets and should be given the flexibility to determine the appropriate level of rate review for their state, within simplified federal standards. If the Department does not modify the criteria by which states are considered "effective," states would need additional time and resources to fully comply with the detailed and extensive requirements for the Department to conclude that a state rate review process is "effective." States need more time to understand and implement the procedures necessary to be deemed "effective," including time to allow state legislatures to act if statutory changes are necessary.

Recommendation: To avoid an unnecessarily duplicative effort, we recommend that the Department simplify the standards that govern whether a state process will be deemed effective and largely defer to state judgment and self-certification that the state believes it has a program that effectively protects consumers. We also recommend that the Department delay the effective date of the regulation to allow states time in implementing the changes necessary for a revised and simpler "effective" review standard.

5. The MLR Should Not Be a Factor In Determining Unreasonableness

The Proposed Rule indicates that the Department will evaluate the unreasonableness of a rate increase based on several considerations. One of those considerations is whether or not the projected medical loss ratio ("MLR") exceeds the federally mandated

retrospective MLR. The ACA establishes a federal retrospective MLR standard of 80% for Individual and Small Group markets, 85% for Large Groups. This is very problematic.

First it is important to recognize that the calculation of federal MLR is very different than the calculation of premium rates. The MLR is calculated using the actual amount spent on medical claims and quality of care activities in the past. On the other hand, premium rates are calculated based on anticipated future experience. As a result, it would be unsound, unwise and unnecessary to try to use the retrospective federal MLR when analyzing prospective state rate filings.

It is unsound to apply federal MLR standards prospectively to a rate filing's projected MBR because of actuarial differences between the two calculations, including:

1. The federal MLR regulations themselves recognize that the MLR standards should not apply to all cases. The regulations adjust thresholds for blocks of business that are not large enough to be statistically credible and potentially for the richness of the benefit offerings -- which means that for particular pools the actual applicable federal standard could be much lower.
2. The MLR requirements may not apply at all to business with less than 12 months of experience; in contrast, rate filings apply to all business newly written or renewed during the period covered by the filing.
3. For some business presently, and for all business beginning in 2014, the MLR calculation will utilize a multiyear experience calculation to enhance the credibility of the results; prospective rate filings do not.
4. MLR is on a calendar year basis for all plans; rate filings cover specific effective dates and will cross calendar years in many cases.
5. Rate filing experience is state and product specific to reflect the medical costs in each market, while MLR pools are generally defined by the situs of the group contract. A rate filing may include members from other MLR pools (*e.g.* members whose employers are from other states) and not include all members in the state's MLR pool (*e.g.* members living in other states employed by in-state businesses). Therefore, the experience included in a rate filing will not be a simple subset of the state's MLR pool.
6. For purposes of the federal MLR calculations, "premiums" exclude amounts that insurers pay for taxes and licensing fees, and "medical costs" include expenses associated with programs that improve the quality of care; rate filings contain no such adjustments.

It is unwise to import the federal MLR requirements into rate review because the resulting rates would be subject to unnecessary volatility in rates year over year, destabilizing the marketplace and potentially reducing consumer options for coverage. Enforcing the federal MLR standard on a prospective basis will have the unintended consequence of pushing MLRs to levels consistently and significantly above the applicable federal minimum. This is because the standard, applied prospectively, does not benefit from the spreading of risk across larger blocks of business and across multi-year periods. This would drive even more insurers out of state markets that already suffer from a lack of competition.

Importing federal MLR requirements into the analysis of prospective state rate filings is also unnecessary because the rebate mechanism of the MLR requirements will

sufficiently deter insurers from filing for rates that are too high (which would result in MLRs that are too low). The risk of destabilizing the market should not be incurred in any event, but it especially should be avoided when adequate protections already exist against the possible harm of excessively high premiums. The federal MLR requirements, in the form of rebates and penalties for repeated experience below the minimum, are effective and sufficient mechanisms in meeting the intentions of health care reform. The specific design of the new federal law will ensure that consumers are protected by requiring insurers who may price their product too high to provide rebates to consumers.

Recommendation: Because failure to meet the MLR standard does not accurately indicate whether a rate increase is excessive, we recommend that the Department remove the consideration of an MLR that does meet the federal standard as a factor in determining whether a rate increase is excessive.

6. Revise the Effective Date of the Proposed Rule

The Proposed Rule provides that the regulation will be effective for rate increases filed in a state on or after July 1, 2011, or effective on or after that date in states that do not require rate increases to be filed. 45 C.F.R. § 154.200(a)(1). Aetna generally supports the Department's decision to apply the rate review rule prospectively only to increases filed or effective in a state after the regulation's effective date. However, the July 1, 2011 date does not give insurers sufficient advance notice to comply with the rule's new requirements. This will lead to consumer confusion and frustration. In addition, failure to delay the effective date will likely lead to increased burden on the Department itself, as it will be required to review rates in all states that have not yet been able to meet the "effective" criteria.

First, insurers typically begin their analysis of possible rate adjustments at least six months before the rate will be effective. Rate adjustments that should be effective July 1, 2011 have been in development from the beginning of 2010. The Proposed Rule was issued December 23, 2010 and while the date of a final regulation is unknown, is unlikely to be before late spring or early summer. As such, insurers may be required to recreate a substantial and detailed rate filing for the Department even in instances where rates have been thoroughly reviewed by a state.

For example, a typical timeline in a state that approves rate filings in 120 days or less would be:

February 2011:	rate review process begins
April 2011:	rate filing submitted to state/Department
August 2011:	system testing begins
September 2011:	rates must be delivered to billing system
October 15, 2011:	target date for delivery of notification of rates
January 2012:	rate effective date

Second, consumers will benefit from a delayed effective date. Given the tight time frame under the Proposed Rule if the Department does not delay the effective date, it is possible that any review by the Department will occur *only after* the rate is effective in a state. Such a retroactive review provides no benefit and may actually harm consumers. Given that the primary value of the rate review statute is to educate consumers before

they make their health insurance coverage purchase, the proposed regulation should be delayed in order to ensure that any review pursuant to the regulation is performed with sufficient lead time to permit consumers to make choices based on the results. And finally, states need time to implement the additional procedures.

Recommendation: Given that a final regulation will not occur until later this year, we recommend an extension of the effective date that recognizes that insurers require a substantial lead time to incorporate the new rules into their rate filing process. In addition, states need time to implement the new procedures. Therefore, we recommend the effective date for the final rule should be the later of July 1, 2012 or when the majority of states have been recognized as having an effective review process by the Department. The Department should publish the final rule and the list of effective rate review states at least six months prior to its effective date. If the final rule is delayed beyond June 30, 2011, then the effective date should be at least 6 months after the final rule is published.

7. The Department Should Structure the Review Process to Determine "Unreasonableness" Before Rates Take Effect

The draft rule does not set a deadline for the Department to make its determination and, more specifically, does not require the Department to make its determination before the rate takes effect. 45 C.F.R. § 154.255(a)(1). This approach harms both consumers and insurers. If a rate's "reasonableness" is important to consumers, they should know what rates are "reasonable" before they decide what insurance to buy. Similarly, if one of the law's goals is to reduce the number of "unreasonable" rates in the marketplace, determining whether a rate is reasonable before it takes effect better promotes that goal. Finally, the law's goal of encouraging insurers to limit rate increases to "reasonable" levels will be best promoted by a process that lets them know whether rates are viewed as reasonable before they take effect. If a determination by the Department is made in advance, then an insurer will have the capacity to change the rate and that benefits consumers. No consumer is helped by a tardy declaration that a rate is unreasonable.

Of course, the Department needs adequate time to review rates. For that reason, the regulation should (1) require insurers to file rates a specified time in advance of their effective date and (2) require the Department to make its decision in a timely way (or "deem" the rates to be reasonable if the Department does not make a decision).

We think the risk of after-the-fact determinations is all the more likely if the Department does not change the ten percent threshold (discussed above) and the criteria for a state to be "effective." These two items would result in a high volume of federal reviews as most states would not be considered effective rate review states.

Recommendation: We recommend that if an insurer properly and timely files its rate and supporting documentation with the Department, the Department will review and make a determination of whether the rate is "unreasonable" within 30 days of receipt of the filing and at least 130 days before the rate goes into effect (to allow for appropriate notice to consumers). In the event that the Department does not make such a determination, the rate should be deemed reasonable. For example, for rates that are to be effective on January 1, in many states insurers are required to notify consumers of any new rate no later than November 1. The Department would be required to make its determination no later than October 22. The insurer would be required to file the rate no

later than September 22. This policy will provide insurers needed certainty and avoid the consumer confusion that could result if the Department were to retroactively deem a rate increase "unreasonable."

We note that many states have adopted such deemer policies. We estimate that at least 14 states deem individual, non-HMO rates to be compliant 30 days after filing, at least 11 states deem small non-HMO group rates to be compliant 30 days after filing, and at least another 8 states deem small non-HMO group rates to be compliant sometime between 30 and 90 days after filing.

8. There Should Be No Required Refiling After Adjustment

The Proposed Rule appears to require an insurer to begin the entire process over if, after meeting the threshold and being reviewed by the Department, the insurer decides to lower the rate increase and the increase still exceeds the threshold for review. This process is inefficient and will lead to needless delays that will not benefit consumers. To the extent that a regulator may raise concerns regarding a potential rate increase, the insurer and regulator should be able to discuss and resolve the issue without resorting to a new formal rate filing.

Recommendation: We recommend the Department clarify the Proposed Rule to permit insurers and the Department or state Departments of Insurance to agree to a modified rate without refiling the rate information with the Department.

9. The Required Rate Review Documentation Should Be Limited

Where the Department conducts the rate review, not only are insurers required to provide the rate increase summary and a written description justifying the rate increase (Parts 1 and 2) but insurers are also required to provide detailed additional rate filing documentation (Part 3). The exact scope of Part 3 is unclear in the Proposed Rule. States generally require insurers that are seeking a premium increase to submit actuarial memoranda and other supporting documentation relating to premium calculations, such as trend assumptions. Although we do not have the Department's actual rate filing form and therefore cannot comment on precisely what information the Department will require to be provided in Part 3, the extensive and detailed list included in the Proposed Rule is filled with information that could be highly confidential and if published on the Department's website will not be easily understood by consumers shopping for health insurance coverage. 45 C.F.R. § 154.215(g).

Consumers are unlikely to be well served by the disclosure of the entire rate filing (Part 3), including the actuarial justifications. Consumers and small employers are most likely to base their buying decisions on a comparison of premiums, benefits, and other plan features (*e.g.*, provider network participation) available to them. It is unclear to what extent any further supporting information regarding the methodology by which the premiums are calculated would be meaningful to the consumer's ultimate purchasing decision and in fact, it is likely to be confusing and unhelpful. To the extent that information must be disclosed to the public, the rate increase summary (Part 1) and written description justifying the rate increase (Part 2) are extremely detailed and provide appropriate and sufficient information to consumers purchasing health insurance coverage.

The Proposed Rule anticipates that insurers may have significant confidentiality concerns through its reference to the Department's Freedom of Information Act ("FOIA") regulations. The Proposed Rule states that all of the contents of the rate review filing will be publicly disclosed, unless the insurer takes the affirmative step to designate certain information "confidential." 45 C.F.R. § 154.215(i)(2)(i). In that case, the Department will review the information under its FOIA guidelines to determine if the Department believes that the information meets the FOIA requirements to be considered confidential. 45 C.F.R. § 154.215(i)(2)(ii). If so, the information will not be posted. If not, the information will be posted. *Id.*

While Aetna appreciates the Department's effort to address of the industry's legitimate confidentiality concerns, the Proposed Rule's solution is insufficient. In short, the Proposed Rule requires the disclosure of vast amounts of proprietary data (*see, e.g.*, section 154.215(g))—far beyond what the plain language of the statute appears to anticipate. Further, the disclosure of the information, particularly that information requested in section 154.215(g), serves no useful purpose for anyone except industry competitors. For example, the rate filing documentation required includes the "reason" for the increase, including supporting documentation. The reason for an increase may be the provider cost trend. The supporting documentation for that trend may be provider contracts or rates. Requiring the disclosure of this sort of clearly confidential and proprietary information is anti-competitive. In this respect, we note that most states do not make rate filing information like actuarial justifications public.

Recommendation: We recommend that at most the Department post only the required rate increase summary (Part 1) and justification (Part 2) and only in cases where the rate *has been determined to be unreasonable*. To the extent that consumers find rate increase information helpful, this is the information most likely to assist them in their purchase decision. As noted above, the rate filing documentation itself (Part 3) is unlikely to assist consumers and, is likely to consist of proprietary or otherwise confidential information.

Further, we recommend that the Department consider all information submitted pursuant to section 154.215(g) (Part 3) as confidential and proprietary business information, not appropriate for disclosure under FOIA. Finally, we request that the rate review filing form developed by the Department be subject to the notice and comment process.

10. Preliminary Justifications Should Be Abandoned In Effective Review States and Not Published In Departmental Review States

The Proposed Rule requires a health insurance issuer to submit a preliminary justification for each rate increase that meets the threshold for review. 45 C.F.R. § 154.215(a). In all circumstances, the preliminary justification must include a rate increase summary (Part 1) and a written description justifying the rate increase (Part 2). 45 C.F.R. § 154.215(b).

The rate increase summary (Part 1) must include: historical and projected claims experience; trend projections related to utilization, and service or unit costs; any claims assumptions related to benefit changes; allocation of the overall rate increase to claims and non-claims costs; per enrollee per month allocation of current and projected premium; current loss ratio and project loss ratio; three year history of rate increases for the product associated with the rate increase; and employee and executive

compensation data from the health insurance issuer's annual financial statements. 45 C.F.R. § 154.215(e). The written justification (Part 2) must include: a narrative describing the data and assumptions that were used to develop the rate increase, including an explanation of the rating methodology; an explanation of the most significant factors causing the rate increase, including a description of relevant claims and non-claims expense increases; and a description of the overall experience of the policy, including history and projected expenses and loss ratios. 45 C.F.R. § 154.215(f).

Insurers are required to submit this preliminary justification (Parts 1 and 2) to the Department and, if it will accept it, to the applicable state. 45 C.F.R. § 154.215(c). The preliminary justification must be submitted whether the Department is completing the rate review or whether the review is being done by an "effective" state, and the Department will promptly post all of the information submitted in a preliminary justification on its website. 45 C.F.R. § 215(i).

The ACA is clear that insurers are required only to justify "unreasonable" rate increases. PHSA § 2794(a)(2) (The rate review process "shall require health insurance issuers to submit to the Secretary and the relevant State a justification for *an unreasonable premium increase* prior to the implementation of the increase.") (emphasis added). Insurers are not required to justify rate increases that the Department believes *might* be unreasonable, subject to review.

Not only is the preliminary justification requirement unsupported by the statute, it is misleading. Requiring insurers to justify their rate increase erroneously suggests that any increase over 10 percent is, or likely is, unreasonable. Even the Department's title erroneously suggests that any rate subject to the justification requirement is unreasonable. Labeling the justification "preliminary" indicates that it is simply an introductory or draft justification—not that it is justifying a rate that has not been determined to be unreasonable and is merely subject to review. This is particularly true because unreasonable premium increases are required to be justified. No disclaimer, no matter how artfully worded, will cause consumers to see the difference between rates supported by preliminary justifications that are merely being reviewed for "possible" unreasonableness, and rates, supported by the 'final' justifications, that have been determined to be unreasonable. To the average consumer, these two justifications will be indistinguishable and all rates posted on the Department website will be tainted. By requiring a preliminary justification, and posting it on its website, the Department is effectively labeling any increase over any "threshold" as presumptively unreasonable.

This provision not only goes well beyond the statutory requirement, but it will impose excessive administrative costs onto the health care system at a time when the industry is striving to improve efficiency.

Recommendation: We recommend that the Department drop the requirement that a preliminary justification (Parts 1 and 2) be filed for states that have an effective process. The requirement exceeds the scope of the statute, creates needless administrative burdens and costs on insurers, tends to mislead the consumer and prejudices insurers whose rates ultimately are determined to be reasonable. For those states that do not have an effective process, to avoid needless consumer confusion we recommend that the preliminary justification (Parts 1 and 2) not be posted on the Department's website unless and until the rate is determined to be unreasonable.

11. Measurement of Trigger and Review of Rates Should Occur at the Rate Filing Level

The Proposed Rule requires that rates be reviewed on a "product" basis. 45 C.F.R. § 154.215(a). A product is defined as "a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a State." 45 C.F.R. § 154.102. The preamble states that each "filed 'product' may include variable options (such as different cost-sharing or deductible requirements)". 75 Fed. Reg. at 81011. The Proposed Rule allows for aggregate filing and review only if the claims experience of all products has been aggregated to calculate the rate and the rate increases are the same across all such products.

States generally permit the aggregation by legal entity or market serviced (*e.g.*, the insurer's individual HMO business is aggregated in one filing; the insurer's individual PPO business is aggregated in another, separate filing; small group HMO business is aggregated in a separate filing; and small group PPO business is aggregated in a separate filing). Further, in some states, once a rate has been filed (on a legal entity basis, for example), the insurer is not permitted to disaggregate the products for other purposes. It is unnecessary and costly to require insurers to disaggregate products for purposes of the Department's review.

It is especially problematic that the Proposed Rule only allows a consolidated review if all of the rates increases are uniform. Actual premium rate increases may be different for the different benefit packages within a state, due to several factors.

First, claim leveraging will have very different impacts on trends for benefit plans with different degrees of cost sharing. As we discussed above, premiums for plans with a higher deductible will go up faster than other plans due to the higher increases they will experience in covered medical costs. For example, a member with $4,000 in annual costs this year may be expected to have $4,400 for next year. If the benefit plan is a $100 deductible, then the covered medical costs would increase from $3,900 to $4,300, or a 10.3% increase. If the same member has a $1,000 deductible, the covered medical costs would increase from $3,000 to $3,400, or a 13.3% increase. This increase in medical costs translates into a similar increase in premium.

Second, plans with different network structures or benefit features may experience different levels of utilization of medical benefits. Third, products with different network configurations may experience different increases in provider compensation, resulting in differences in projected medical costs trend. As a result, we believe that the Department should not require rate increases to be identical before products may be aggregated.

Aggregation by rate filing would also lessen the administrative burden and costs required for rate filings and review. Aetna currently submits over 400 rate filings each year for individual and small group. If the Proposed Rule requires those filings to be disaggregated, it would exacerbate the costs of each of those filings. Allowing aggregation consistent with state practice for rate filings is important to avoid unnecessary administrative expenses for both insurers and insurance department personnel – all of which are costs that ultimately are carried by the consumer.

Recommendation: We recommend that current state practices with regard to aggregation of rate filings continue. At a minimum, we request deletion of the provision that all rate increases be uniform in order for the rate filing to be reviewed in aggregate.

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Aetna is pleased to have the opportunity to provide comments regarding the rate review process under PHSA section 2794. Thank you for considering our comments. Should you have any questions, please feel free to contact me.

Sincerely,

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